DOCUMENT RESUME

ED 036 015 EC 004 882

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TITLE	FAMILY CONCEPTS AND EMOTIONAL DISTURBANCE IN THE FAMILIES OF DISTURBED ADOLESCENTS WITH NORMAL SIBLINGS. RESEARCH REPORT, VOL. 5 NO. 3.
INSTITUTION	INSTITUTE FOR JUVENILE RESEARCH, CHICAGO, ILL.
SPONS AGENCY	ILLINOIS STATE DEPT. OF MENTAL HEALTH.
PUB DATE	68
NOTE	27P.; BASED ON A PAPER PRESENTED AT THE 1968 ANNUAL CONVENTION OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION
AVAILABLE FROM	RESEARCH PROGRAM IN CHILD DEVELOPMENT, 232 EAST OHIO STREET, CHICAGO, ILLINOIS 60611
EDRS PRICE	EDRS PRICE MF-$0.25 HC-$1.45
DESCRIPTORS	*ADJUSTMENT (TO ENVIRONMENT), *EMOTIONALLY DISTURBED, *EXCEPTIONAL CHILD RESEARCH, FAMILY ATTITUDES, *FAMILY ENVIRONMENT, FAMILY RELATIONSHIP, PARENT ATTITUDES, *PERCEPTION

ABSTRACT

TO INVESTIGATE THE HYPOTHESIS THAT THE DEGREE OF DISTURBANCE SHOWN BY A CHILD IS A FUNCTION OF HIS PERCEPTION OF FAMILY ADJUSTMENT, TWO GROUPS OF 13 FAMILIES EACH WERE STUDIED. SUBJECTS WERE ADOLESCENT PATIENTS, NORMAL SIBLINGS, PARENTS, AND A NORMAL CONTROL GROUP OF ADOLESCENTS AND PARENTS. PERCEPTIONS OF THE FAMILY AND IDEAL FAMILY WERE OBTAINED ON THE FAMILY CONCEPT Q SORT. PATIENTS WERE SIGNIFICANTLY LOWER THAN THEIR SIBLINGS ON PERCEIVED FAMILY ADJUSTMENT AND SATISFACTION WHILE NORMAL SIBLINGS DID NOT DIFFER SIGNIFICANTLY FROM NORMAL CONTROLS. PARENTS OF PATIENTS SCORED LOWER THAN PARENTS OF NORMAL CONTROLS. CLINIC PARENTS BOTH SAW THE FAMILY AS UNRELAXED; THEY PERCEIVED INVOLVEMENT AND SOCIABILITY BUT NOT AN EFFECTIVE OR INTERPERSONALLY SATISFYING SOCIAL UNIT. (AUTHOR/RJ)

ED036015

FAMILY CONCEPTS AND EMOTIONAL DISTURBANCE IN THE FAMILIES OF DISTURBED ADOLESCENTS WITH NORMAL SIBLINGS

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State of Illinois
Department of Mental Health
INSTITUTE FOR JUVENILE RESEARCH

ED004 882E

Research Program in Child Development
232 East Ohio Street
Chicago, Illinois 60611

RESEARCH REPORT
1968 Vol. 5 No. 3

Abstract

Family Concepts and Emotional Disturbance in the Families of Disturbed Adolescents With Normal Siblings

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The assumption that family factors may be pathogenic for emotional disturbance has generally failed to be substantiated. It was hypothesized that this relationship depends on the way in which family conditions are subjectively perceived by the family members. Ss were adolescent patients, normal siblings, parents, and a normal control group of adolescents and parents. Perceptions of the family and ideal family were obtained on the Family Concept Q Sort. As predicted, patients were significantly lower than their siblings on perceived family adjustment and satisfaction; normal siblings did not differ significantly from normal controls; and parents of patients were lower than parents of normal controls. Distinctive differences were found in the primary content factors of the family concepts of each child and parent group.

Family Concepts and Emotional Disturbance in the Families of Disturbed Adolescents With Normal Siblings[1]

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Many studies have found that persons with emotional disorders have early family backgrounds filled with emotional difficulties, such as rejection (Vogel, et al., 1964), child-parent conflict (McKeown, 1950; Vogel and Bell, 1960), inter-parental conflict (Fisher, 1959), broken homes (Madow and Hardy, 1947), absence of one parent (Ingham, 1949), weak father figures (Millar, 1961), "smothering" mothers, (Sperling, 1951; Glauber, 1951) and prolonged sibling conflict (Ingham, 1949). These findings have led many investigators to refer to these early family environments as "pathogenic", and as central causative factors in emotional disorders.

Nevertheless, controlled and systematic investigations have rarely found a direct relationship between family background and psychopathology. Stevenson (1957) states that "if the experiences of childhood importantly influence the later personality, we should expect to find some correlation between such experiences and the later occurrance of mental disorder. In fact, no such correlations have ever been shown (p. 153)." Renaud and Estess (1961) report that extensive interviews with 100 military men revealed a great deal of material regarding family background of a supposedly "pathogenic" nature, yet these men were rated high on emotional adjustment. Similarly, after an extensive review of the literature on the etiology of psychopathology, Frank (1965) concludes

that there are no evident factors which distinguish the backgrounds of families of schizophrenics, neurotics and behavioral disorders from the families of normal controls, or from each other. In spite of the lack of corroboration, it is still generally accepted that family background strongly influences later emotional adjustment.

A related issue is raised by the view that the patient seeking treatment, especially if that patient is a child, is the representative of a wider problem permeating the entire family unit (Ackerman, 1958; Handel, 1967; Bell, 1962). However, it is possible to find clinic patients from supposedly pathogenic families who have non-disturbed siblings (Vogel and Bell, 1960). To the extent that this is true, it casts doubt on the assumed relationship between family factors and emotional disorders. If the family environment is the principal pathology producing agent, the question arises as to why one child's reaction to this environment is pathological while that of another is not?

One possible explanation for the lack of evidence for the family environment-emotional health relationship is that the objective presence of a pathogenic family environment may be only as important as the individual's subjective interpretation of that environment or, more simply, as the particular meaning that it has for him (e.g., Frank, 1965; Hess and Handel, 1959). One child may perceive his family experience with such severity that it results in psychopathology, while to another it is only mildly disturbing and results in no lasting emotional problems. This possibility allows for the fact that there is no known one-to-one relationship between family factors and psychopathology and that similar objective conditions can exist for both disturbed and

non-disturbed children. This view would, however, predict a difference in the way family conditions are perceived, depending on the degree of disturbance shown by the individual. The present study deals with this prediction for the family view of a disturbed adolescent child and a non-disturbed adolescent sibling. For control purposes, comparisons are also made with adolescent children from non-clinic families, and between the parents of the clinic and non-clinic groups.

An assumption of the approach taken in the study is that a person's view of his family experience, his "cognitive scheme" of the family, consists of a coherent and potent set of perceived attributes (van der Veen, et al., 1964). This set of attributes has been termed the person's "family concept" and a test (described below) ahs been developed for its assessment. In previous studies (cf. van der Veen, 1965) measures of family adjustment, family satisfaction and the congruence of family concepts have been obtained by means of the test and have been shown to differentiate between the parents of disturbed children and parents of well-adjusted children.

The present study is a preliminary investigation of the hypothesis that the degree of disturbance shown by the child is a function of his perception of the family, especially of the degree of family adjustment and satisfaction shown by his view of his family. It was predicted (1) that there is less family adjustment and satisfaction in the family concepts of disturbed children, than in their siblings or normal controls; (2) that the siblings and normal controls do not differ on these variables; (3) that the family concepts of parents of disturbed children show less adjustment and satisfaction than the concepts of

parents of non-disturbed children; and (4) that there are distinctive differences in the principal content dimensions of the family concepts of each of these groups.

The first two predictions test the hypothesized relationship between perceived family experience and degree of disturbance. The third replicates an hypothesis tested in previous studies: that factors in the parents' family concepts are associated with the child's degree of disturbance. The fourth prediction explores the relationship between the content of family concepts and the person's adjustment and family position.

Method

Two groups of families were tested. The clinic group had applied to an outpatient clinci for help with a problem concerning an adolescent child. The other group was selected from the community, through the ninth grade school enrollment lists. Thirteen families were selected for each group.

For the clinic group, only families with at least two children 11 years of age or older were used. One of these children, the identified patient, was professionally diagnosed as emotionally disturbed, with the exclusion of psychotic or organic disorders. Families in which more than one adolescent was known to be disturbed were excluded. Problems included predominantly aggressive, acting-out ones (4 boys and 2 girls), withdrawal and immaturity (2 boys and 2 girls), nervousness and depression (1 boy and 1 girl) and school phobia (1 boy). Several of these cases also involved psychosomatic symptoms. At the time of testing 10 of the families were on a waiting list and the other 3 had had less than 3 interviews.

The community families were selected from a larger sample of 25 families on whom data were already available. This group of families was obtained from children in the ninth grade whose names had been placed by a teacher in either the lowest or highest quartile of general school adjustment. They therefore represent a broad range of adjustment in a school setting. An unusually high number of the fathers in the tested group had graduate education (12 out of 25), probably due to the school's proximity to a large university. These families were dropped from the final sample in order to make the social status of the non-clinic families as similar to the clinic ones as possible (see Table 1). The distribution of adjustment in the final non-clinc sample was nearly equal: 7 better and 6 worse adjusted.[2]

Insert Table 1 about here

Family characteristics of the two groups are presented in Table 1. The groups are well matched, with the exceptions of somewhat larger families in the clinic group and a higher proportion of females in the non-clinic children.

Testing was done in the home on both parents and all children 11 years of age or older in the clinic group, and on both parents and the 9th grade child in the non-clinic group. This resulted in test data from 100 persons for the samples we used. Family descriptions were obtained on the Family Concept Q Sort (van der Veen, et al., 1964). The Family Concept Q Sort consists of 80 items that are sorted into nine piles, ranging from "least like" to "most like" the family (or the ideal family), following the usual forced-sort procedure. Examples of the

items are "We are an affectionate family," "We have very good times together," "We just cannot tell each other our real feelings," "Accomplishing what we want to do seems to be difficult for us," "We resent each other's friends."

As can be seen, each item concerns the entire family unit and not individual relationships within the family. This mode of item construction reduced the complexity of describing family experience, made the test results from different family members comparable, and provided a description of the most meaningful and salient aspects of a person's family experience regardless of the specific relationships involved.

Each subject was first asked to sort the items for his family as it is now, his real family concept, and then to sort them for the way he would ideally like his family to be, his ideal family concept. In addition to specific item scores, measures of perceived family adjustment and family satisfaction were also derived from the test. Family Adjustment is computed from the item placement, on the like or unlike sides of the scale, for 48 of the items on which27 clinicians were in high agreement that they were either like or unlike the ideal family (cf., van der Veen, et al., 1964). An item is counted if it is placed on the same side (like or unlike) as it was placed by the professionals. The adjustment score can, therefore, range from 0 to 48. Family Satisfaction is the extent to which the real family concept resembles the ideal family concept. It is computed by means of the product-moment correlation between a person's real and ideal family sorts. The correlation score was transformed to Fisher's z score for the data analyses. The reliability and validity of the Q Sort and the measures

based on it have been found to be adequate (van der Veen, 1965)[3].

The independent variables of the design are the degree of emotional disturbance and membership or non-membership in a family with an emotionally disturbed child. The design permits an analysis of contrasts concerning emotional disturbance within the same family (Patients vs. Normal Siblings) and between families (Normal Siblings vs. Normal Control Children, Clinic vs. Non-Clinic Parents), according to the predicted relationships. The dependent variables are family adjustment as reflected in the person's family concept, the person's satisfaction with the family in terms of real-ideal agreement, and the content structure of the way the family is viewed, obtained by means of factor analysis of each group's real family concepts.

Two types of sibling scores were utilized for each clinic family, because 6 of these families had more than one normal adolescent sibling. One was the mean score for all the siblings (excluding the patient) in a family. The other was the score of the sibling of the same sex who was closest in age to the patient. For two multiple-sibling families that did not have a same-sex sibling the one closest in age to the patient was used.

Means and standard deviations of the family satisfaction and family adjustment scores for the Patient, Sibling and Non-Clinic Children groups, and the Clinic and Non-Clinic parents are presented in Table 2. The results of the t-tests between the group means on these measures are given in Table 3. T-tests for paired values were used for comparisons within the same family. Clinic parents had significantly higher variance than non-clinic parents, and the p-value was corrected

by the method suggested in Winer (1962, p. 37), for the family adjustment score.

Insert Tables 2 and 3 about here

The results show that perceived family satisfaction and adjustment were significantly higher for both the siblings and the non-clinic children than for the patients, and that the siblings did not differ significantly from the non-clinic children. They also show that both the non-clinic fathers and mothers were significantly higher on family adjustment and satisfaction than the clinic fathers and mothers. The significantly higher variance for the family adjustment scores of the clinic parents is due to the large range of the scores in this group.

To analyze the main content dimension of a group's real family concepts, the 80 items were intercorrelated and factored by means of the centroid method. Only the initial unrotated factor (after iterating to stabilize the communalities) were used. The initial factor accounts for the greatest amount of variance and is most likely to represent a stable dimension. For the Sibling group the entire sample (n=22) was used, since factor analysis does not assume independence of scores. The percent of variance accounted for by the initial factors ranged from 16.8 to 27.9, with only the non-clinic fathers accounting for less than 21%.

A fairly high, arbitrary, cut-off loading point of .63 (about 40% of the item variance) was set to determine which items were representative of a factor, and the group mean was computed for each of these items. To simplify the factor descriptions, only the items with means

on the "like" (4.50 to 8.00) and "unlike" (0.00 to 3.49) sides of the Q-sort scale are presented in Tables 4, 5 and 6. The items whose means fell in the neutral zone (3.50 to 4.49) were also considered, but are not presented here to conserve space.

Table 4 gives the positive and negative items for the initial factor of each child group. Disturbed children as a group stress the importance of their families, what the family members think of one another, and their dependence on each other. Consistent with this dependence is their desire for their family to not be different, and possibly also a lack of involvement in religious activities. In contrast, their non-disturbed siblings see the family as strong, competent and task-oriented. The principal content for the family concepts of the non-clinic children is characterized by positive family relationships: good times, satisfaction, consideration, good spirits and successful adjustment, with the absence of conflicts, shame and misunderstanding. The contrasting emphases in these views provides some evidence for the prediction of differences in the principal dimensions of the family views of the child groups.

Insert Table 4 about here

For the parents, it can be seen from Table 5 that the clinic fathers and non-clinic fathers also differ. The principal factor for the clinic fathers involves consideration, pride, knowing and caring for one another, responsibility for difficulties, and also the presence of the unhappiness and tension. In contrast, the non-clinic fathers stress family conformity: pleasing one another, good manners, and

family organization. They also see individual ambition, in the form of success and prestige, as not important in their families.

Insert Table 5 about here

For the clinic mothers (see Table 6) family sociability, liveliness and shared values are important. They agree with the clinic father factor that the family is not relaxed and also see a lack of organization in family activities. In contrast to this picture of unorganized sociability, the factor of the non-clinic mothers has in common the presence of affection in the family, good times, getting along well, and no need for help.

Insert Table 6 about here

Discussion

The results were consistent with the predicted relationships. Family satisfaction and family adjustment were clearly lower in the family concepts of the disturbed children than in their normal siblings or normal controls, while they were not lower in the family concepts of the normal siblings than in the normal controls.[4] The family concepts of the parents who had a seriously disturbed child were markedly lower on adjustment and satisfaction than those of parents of normal children. In addition, the principal factors of the various groups of children, fathers and mothers showed distinct differences in their item content.

The results lend credence to the importance of the way family life is viewed by both the parents and the children for the presence or

absence of emotional disturbance in the child. But some caution is necessary in interpreting these findings in an area as complex as the one under study. Controls were necessarily only approximated and measurement error may have been considerable. Some conditions, such as the effect of actually having been interviewed in a clinic, could not be adequately evaluated. The question of the specific effects of the adolescent period on family structure also needs to be considered, especially in relation to the sex of the child. It should also be noted that the present study does not test the direction of causation, and does not assume that the direction is simply that of child disturbance being caused by the family views of the child or the parents. The model preferred is an interactive one, that behavior and attitudes influence and modify each other in a continual interplay in which both are critically important (cf. Renaud and Estess, 1961). The modification of either could lead to a cycle of beneficial or detrimental change.

In addition to the tests of the hypotheses, it would be of interest to know whether the clinic parents view their family's adjustment and satisfaction as higher than their disturbed child and also whether there were any other consistent differences within and between the family groups. T-tests were calculated between all pairings of means, both within and between the groups. Using two-tailed significance tests, it was found that the patient was clearly lower ($p < .05$) than the mother, but not significantly below the father. In the non-clinic families there were no significant differences between children, fathers and mothers. Except for the similar scores of normal siblings and non-clinic children, all other contrasts between clinic and non-clinic

family members showed significantly lower scores in the clinic families.

The pattern of these findings suggests that there may be three broad levels of family functioning reflected in the family concept measures. The lowest level is shown by the clearly maladjusted member, the identified patient. His family views show the greatest dissatisfaction and maladjustment. An intermediate range of satisfaction and adjustment is shown by the immediate relatives of the identified patient, presumably by factors which cause or are caused by the patient's disturbance. While they are presumably functioning more adequately than the patient, they do show some stress in their family views. The highest levels of satisfaction and adjustment are found in non-clinic families with a well-adjusted child. This group shows a consistent picture of low stress and high satisfaction. These levels in the association between family views and disturbance are consistent with theoretical expectations and with clinical experience, namely, that the patient's family experience is most disturbed, that his immediate family relations are not experiencing as much disturbance but are influenced by and influencing his disturbance, and that well-adjusted families are relatively free of perceived stress.

The factor analyses provide some leads for understanding the way in which the non-disturbed sibling manges to minimize family stress. To briefly characterize the distinctive aspects of the principal factor in each group: the disturbed children perceive emotional dependence in the family, their siblings view the family as competent and task-oriented, while the normal controls see it as a source of positive experience with good interpersonal relationships. The siblings, therefore, clearly

differed from the normal controls in not stressing the positive interpersonal aspect of family life, but they also avoid the emotional dependent features associated with the disturbed child's view. It may be important for the normal sibling in the disturbed family to stay away from personal involvement and to instead be oriented toward adequacy and achievement, to doing well. He may avoid problems by avoiding feelings, by filling a social role, and by gaining satisfaction from accomplishment rather than intimacy. It should follow that well-functioning children that come from families with a disturbed child would be impatient with feelings, extroverted, active, and strive for leadership. This is a prediction that further research could readily test.

Of interest here is the "scapegoat" hypothesis of Vogel and Bell (1960). The results suggest a more interactive picture than that of a child simply selected by the parents as the target for their problems. The selection of a child as the scapegoat is likely to depend on the personality of the child, in addition to his availability within the family. A child who is oriented toward emotionality, dependency and personal involvement is more likely to become the focus of the parents' own problems than one who is less emotionally responsive and who gains satisfactions from achievement, competition and social role mastery. Also, the latter child is not likely to gain satisfaction from, and thereby reinforce, the emotional involvement of the parents.

With respect to the parents' family concepts, the higher family satisfaction and adjustment of the non-clinic parents confirm previous similar findings (van der Veen, 1965; Hurley and Silvert, 1966). They

lend weight to the role played by these variables in fostering and/or maintaining the child's emotional difficulties. The factor analyses of the parents' family concepts suggest that the family concepts of the fathers and mothers in non-disturbed families are complementary. The focus on adequate family organization by the father complements the concern with closenss and enjoyment by the mothers. On the other hand, the views of the clinic mothers and fathers are not complementary. The clinic fathers stress family involvement, while the mothers are concerned about sociability both in and out of the family. Both see the family as unrelaxed.[5] Thus the disturbed child is in a family where parents perceive involvement and sociability but not an effective or interpersonally satisfying social unit.[6] It is likely that these parental views in the clinic family encourage a focus on coping and adequacy by the normal sibling of the disturbed child, since he thereby avoids the emotional problem areas in the family while at the same time making a highly needed contribution to its effectiveness.

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Footnotes

1. The article is an expanded version of a paper presented at the 1968 Annual Convention of the American Psychological Association (Novak and van der Veen, 1968). Work on the study has been supported in part by USPHS Grants MH 13633-01 and 15503-01 and General Research Support Grant Fr-05666-02. It is based on a master's thesis by the first author (Novak, 1968) under the direction of the second author. Sincere gratitude is expressed to Marjorie Meers, M.A., who assisted in obtaining the data, and to Arthur W. Hoyt, M.D., Medical Director, Topeka Family Service and Guidance Center, for permission and assistance in obtaining clinic families.

2. In the summary published in the Proceedings of the convention presentation (Novak and van der Veen, 1968), the non-clinic sample was mistakenly described as consisting of the more highly adjusted children in the original group. The non-clinic sample actually represents a moderate level of adjustment rather than an unusually high one. The error makes differences between the clinic and non-clinic groups less rather than more likely; therefore, it strengthens rather than weakens the results.

3. A manual and item list for the test, information on its reliability and validity, and a summary of research results are available upon request to the second author.

4. The somewhat lower means of the normal siblings when compared to the controls may be partly accounted for by a higher proportion of females in the non-clinic group than in the sibling group. Females scored higher, especially on family satisfaction, than the males in these

two groups, though the N's were too small for statistical significance.

5. It should be noted that the greater similarity between the father's and mother's principal factors in the clinic group than the non-clinic group does not mean that clinic parents are in greater agreement on their views of the family. In fact, just the opposite has been shown (van der Veen, 1965).

6. These differences are consistent with Bronfenbrenner's (1961) findings that (a) the father plays a critical role in the socialization of the child and (b) dependent children (here the disturbed child) come from families that lack clear leadership.

Table 1

Descriptive Characteristics of the Clinic and Non-Clinic Families

	Clinic Families (n=13)	Non-Clinic Families (n=13)
Mean number of children	4.3	2.8
Father's education (years)	12.0	13.2
Mother's education (years)	11.8	12.9
Father's occupation:		
Blue Collar	9	8
White Collar	4	5
Mother's occupation:		
Housewife	7	6
Blue Collar	3	1
White Collar	3	6

	Patients (n=13)	Siblings (n=22)	Non-Clinic Children (n=13)
Sex:			
Males	8	12	5
Females	5	10	8
Age (mean)	15	15	15
Birth rank (mean)	2.1	2.0	1.5
School grade (mean)	9.0	9.4	9.0

Table 2

Means and Standard Deviations of Family Adjustment and Family Satisfaction Scores for each Group

Children Groups (n=13)	Family Adjustment		Family Satisfaction (z)	
	Mean	S.D.	Mean	S.D.
Patients	19.5	8.0	.10	.31
Sibling-same sex	24.9	6.2	.39	.35
Sibling-mean	25.3	6.6	.40	.36
Non-Clinic Children	29.6	8.5	.57	.40
Parent Groups (n=13)				
Clinic Fathers	24.1	9.8	.27	.46
Clinic Mothers	24.7	10.0	.31	.36
Non-Clinic Fathers	32.3	5.8	.57	.34
Non-Clinic Mothers	34.1	5.5	.73	.39

Table 3

T-tests for Differences in Group Means on Measures of Family Adjustment and Family Satisfaction

Groups	Family Adjustment		Family Satisfaction	
	t	p[a]	t	p[a]
Patients vs. Siblings (s.s)	2.38	.025	3.05	.01
Patients vs. Siblings (mn.)	2.49	.025	3.16	.01
Patients vs. NC Children	3.13	.01	3.40	.01
Siblings (s.s.) vs. NC Children	1.60	n.s.	1.23	n.s.
Siblings (mn.) vs. NC Children	1.43	n.s.	1.26	n.s.
C Fathers vs. NC Fathers	2.49	.025[b]	1.84	.05
C Mothers vs. NC Mothers	2.85	.01[b]	2.83	.01

Note. - C = Clinic family, NC = Non-Clinic family, s.s. refers to the same sex, nearest age sibling; mn. indicates the mean for all siblings.

[a]P-values are for one-tailed tests in the hypothesized direction.

[b]Corrected for significantly higher variance in the C than NC cases.

Table 4

Initial Factor Item Comparisons for the Adolescent Groups

Group	Items Like the Family	Items Unlike the Family
Patients	48. The family has always been very important to us. (.82) 35. We need each other. (.75) 67. It is important for us to know how we appear to others. (.64) 23. We are proud of our family. (.63)	64. We sometimes wish we could be an entirely different family. (-.84) 33. We are a deeply religious family. (.76)
Siblings	70. We are a strong, competent family. (.68)	29. Accomplishing what we want to do seems to be difficult for us. (-.75)
Non-Clinic Families	54. We have very good times together. (.91) 60. We are satisfied with the way we now live. (.77) 48. The family has always been very important to us. (.75) 73. We forgive each other easily. (.71) 80. We are full of life and good spirits. (.68) 43. Together we can overcome almost any difficulty. (.67) 78. We can adjust well to new situations. (.65) 50. We are considerate of each other. (.63)	25. There are many conflicts in our family. (-.93) 40. We are ashamed about some things in our family. (-.78) 37. We do not understand what is causing our difficulties. (-.74) 16. Little problems often become big ones for us. (-.63)

Note. - Factor loadings for the items are given in parentheses.

Table 5

Initial Factor Item Comparisons for Fathers

Group	Items Like the Family	Items Unlike the Family
Clinic Fathers	50. We are considerate of each other. (.82) 23. We are proud of our family. (.76) 34. We are continually getting to know each other better. (.72) 58. We are not as happy together as we might be. (-.67) 63. We have respect for each other's feelings and opinions even when we differ strongly. (.66) 3. We have a number of close friends. (.66) 46. We take care of each other. (.65)	15. It is not our fault that we are having difficulties. (-.89) 49. We get more than our share of illness. (-.78) 20. We do not talk about sex. (-.66) 26. We are usually calm and relaxed when we are together. (.65)
Non-Clinic Fathers	5. Each of us tries to be the kind of person the others will like. (.73) 9. We do many things together. (.69) 6. Good manners and proper behavior are very important to us. (.65)	38. Success and prestige are very important to us. (-.65) 66. We are a disorganized family. (-.63)

Note. - Factor loadings for the items are given in parentheses.

Table 6

Initial Factor Item Comparisons for Mothers

Groups	Items Like the Family	Items Unlike the Family
Clinic Mothers	65. We are sociable and really enjoy being with people. (.66) 80. We are full of life and good spirits. (.66)	42. There are some topics which we avoid talking about. (-.78) 61. Usually each of us goes our own separate way. (-.74) 68. Our decisions are not our own, but are forced upon us by circumstances. (-.72) 26. We are usually calm and relaxed when we are together. (.69) 24. We do not like each other's friends. (-.67) 11. There are serious differences in our standards and values. (-.66) 47. Our activities together are usually planned and organized. (.66)
Non-Clinic Mothers	54. We have very good times together. (.67) 14. We are an affectionate family. (.64)	8. We want help with our problems. (-.83) 21. We get along much better with persons outside the family than with each other. (-.82) 37. We do not understand what is causing our difficulties. (-.82)

Note. - Factor loadings for the items are given in parentheses.